

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-036869**

FILED VS. NOV 10 1959

206

Primary Registration District No. 4817

Registrar's No. 555

STATE FILE NUMBER

RECORDED

1. PLACE OF DEATH a. COUNTY <b>MADISON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>MADISON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>MAYOUAN-MO</b>	Length of stay in 1b	c. CITY OR TOWN <b>MAYOUAN MO</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>NANCY</b> Middle <b>E</b> Last <b>OWAN</b>			4. DATE OF DEATH Month <b>10</b> Day <b>30</b> Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1-23-1881</b>	9. AGE (last birthday) <b>- 78</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	11. BIRTHPLACE (City and state or country) <b>MAYOUAN MO</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>

13a. FATHER'S NAME <b>CHAS. SIMMONS</b>	13b. MOTHER'S MAIDEN NAME <b>JANE GRAHAM</b>	14. NAME OF HUSBAND OR WIFE <b>THOS OWAN</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. <b>492-24-6120</b>	17. INFORMANT Address <b>R.H. KELLY MAYOUAN MO</b>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b>	DUE TO (b) <b>failure</b>	<b>4 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
		20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____

21. I attended the deceased from **10/27/59** to **10/30/59** and last saw her alive on **10/29/59**  
Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>L. W. DeLeyere D.O.</b>	22b. ADDRESS <b>Predericktown Mo</b>	22c. DATE SIGNED <b>11/1/59</b>
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11/3/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>WHITENOR</b>
24. FUNERAL DIRECTOR ADDRESS <b>W. H. Man Mayouan Mo</b>		25. DATE RECD. BY LOCAL REG. <b>11-2-1959</b>
		26. REGISTRAR'S SIGNATURE <b>Florence Hicks</b>

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 2 1959

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Raymond B. Wilson

Licensed Embalmer No. 4884

P. O. Address Frederick

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.